JULY 2010

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Health Care Policy and Constitutional Rights: The Health Care Freedom Amendment

What Washington, D.C. Could Learn from Washington State on Health Care Reform

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ALEC POLICY FORUM (PULL-OUT SECTION)

SPECIAL REPORTS

The Fashion of Model Legislation

BY MICHAEL BOWMAN

What do a fashion designer and a legislator have in common? This is not some bad joke or new scandal, it is a logical question. Just as a designer tracks the latest trends and tries to figure out the styles for the following season, every legislator should contemplate what their legislative agenda is going to look like next year.

Based on 20 years of state legislative experience, I have made an observation that legislators are similar to fashion designers. A fashion designer's models always need to look their best and everyone is watching them. Fashion designers have everyone in the industry looking at their styles and scrutinizing if their layout will be hot or not. The legislator has a variety of individuals and groups looking at their legislative agenda; will it pass or fail? All of this takes planning and a great deal of work.

So what is your "fashion" style? Are you a traditionalist, one who sticks to the basics or are you trendy and know how to stay current with the latest styles; or do you mix it up a little?

Issues come and go! Remember all those bills on term limits, enterprise zones, regional government, flag burning, banning firearms and midnight basketball? Some issues are like the basics in fashion: taxes, crime and education never go out of style. Other issues however fade away.

ALEC has over 800 model bills for you to choose from. In fact, it might be overwhelming, so where do you start? I want to empower you to know your options and provide some simple suggestions. Whether you are looking for legislation on asbestos or vegetative filter strips or everything in between we have model legislation for you.

Current events swing society back and forth. Sometimes what is trendy is something that has been out of style for years. Other times technology dictates that new legislation is the only answer. Having a reservoir of ideas empowers you to be more effective with the right legislation at the right time.

The next time you see a fashion model strut their stuff you can appreciate that you have more in common than most people would expect. ■

Website

On our website we have listed 800 model bills and resolutions ready for you as a member. You can find these bills in several ways. One option is to go directly to "Model Legislation" or Task Force pages and review bills there. Another choice is to type in a search word like "transparency" and you will see all the different types of transparency that we offer.

Policy Initiatives

A new monthly e-mail service which is sent to all our members on our email distribution list is called Policy Initiatives. This once a month email features past model legislation that are timely and have good ideas to implement in your state.

Inside ALEC

This monthly magazine highlights the efforts of legislators and/or private sector members in regards to model legislation. ALEC's staff would be delighted to assist you in connecting with these legislative or private sector champions. Inside ALEC shows you the latest trends in state policy.

Task Force Meetings

Learn about model legislation while it is being discussed and voted on in person. Attending ALEC's Task Force meetings give legislators an opportunity to hear legislation vetted out by both the public and private sectors. This gives legislators unique opportunities to get creative ideas for their own state.

Task Force Directors

ALEC's Task Force Directors are available to help you to find model bills that may be a benefit to your state. They also can help vet solutions to problems you are facing and make suggestions and recommendations for your consideration.

The key to being an effective legislator is knowing the right time to introduce a bill. For example, when government spending is out of control, that is a good time to introduce legislation which offers solutions like transparency and fiscal restraint.

New Model Legislation

Three times a year ALEC distributes by email and in this magazine the newest legislation and resolutions. See page 29 for latest model legislation.

Michael Bowman is senior director of policy and strategic initiatives at the American Legislative Exchange Council.

States Still the Solution

BY SEN. JUDSON HILL (GA)

The federal takeover of health care may be more controversial since its passage than prior to becoming law. While Democrats failed to listen to the people as they advanced ObamaCare, conservatives were and still are listening to health care professionals, to health care providers and most importantly to the people.

Almost every day I walk door to door throughout my Georgia Senate district talking with people I represent. They tell me, "We're having challenges making ends meet and please do something to stop ObamaCare because I'm afraid I can't afford it." ObamaCare restricts individual freedoms and eliminates the free market. It does not improve quality, accessibility or health care affordability but rather will increase costs and decrease access to doctors and nurses. This is not what Americans want.

ObamaCare only created another massive government program. When existing government health programs like Medicare, Medicaid, Tri-Care and CHIP are renowned for inefficiencies, skyrocketing costs, fraud, and poorer health outcomes, Americans don't need nor want another federal health program. People do not want another government bureaucrat choosing what medical care is best for them.

Rather than eliminate Medicare Advantage, which is a successful free-market based health plan for seniors, we should build on this positive experience of market competition and enhance the program to save money and improve health benefits. But the reality is that Medicare Advantage was eliminated to help finance national health care on the backs of fixed-income seniors.

Many believe that the states hold the key to real health care reform. This is especially true today. States must act now before ObamaCare is fully implemented and pass real free-market solutions that prove there are better alternatives; and that conservatives have practical and affordable health care solutions that work.

This year ALEC's model bill, the *Freedom of Choice in Health Care Act* was introduced either as a constitutional amendment or bill in over 40 states as a state solution to preserve patients' ability to make their own decisions about health coverage. My ALEC model bill, the *Health Care Choice Act for States*, has been introduced in almost two dozen states—and passed in Wyoming and Oklahoma—to allow people to purchase affordable health coverage across state lines. And in 2008, *Georgia's Affordable Health Insurance Act* was adopted as an ALEC model health care reform bill and has now been introduced and passed in several states.

In 2008, the Georgia legislature enacted my *Affordable Health Insurance Act* giving state tax breaks to individuals, businesses, and insurers who buy and sell low premium HSA health plans. Millions of Georgians working for over 575,000 small companies can now save millions of dollars enabling many more working families to afford health insurance. The Act also allows Georgians to purchase health insurance with "before tax dollars" and rewards people who stay healthy with partial refunds of their health insurance premiums. The bill's purpose was to give Georgians a patient-centered solution and encourage personal responsibility. These and similar bills must be introduced in states across the country.

Other states have passed free market health care reform measures. State leaders have worked together for years through ALEC to bring fundamental changes to health care—helping to create a more patient-centered system that is prevention focused, affordable, portable, and rewards people for making healthy choices. We must act now to preserve people's freedom to choose their own health care. We must resolve to develop state-based, free-market solutions rather than accept more government control of our lives.

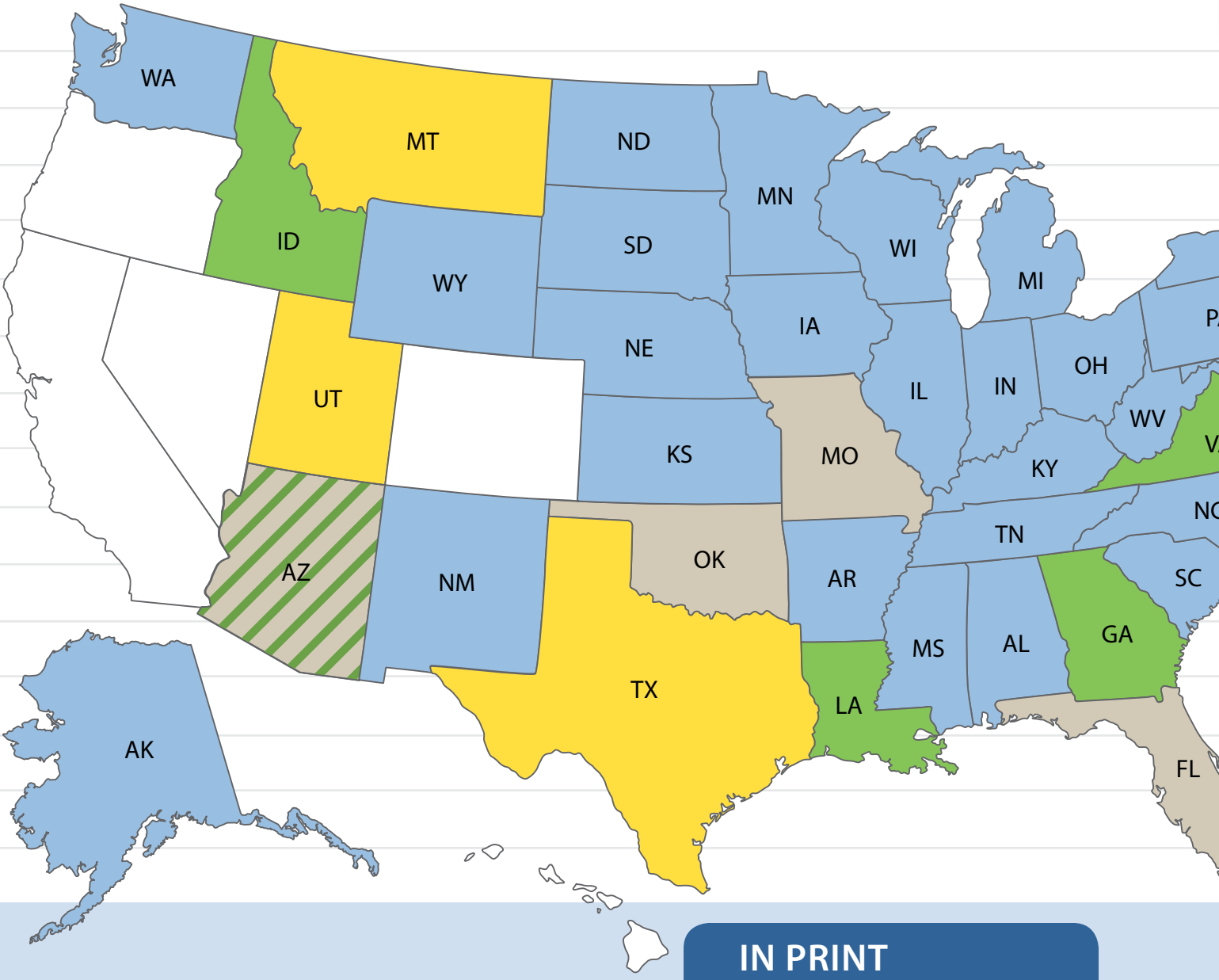
Judson Hill represents the 32nd District in the Georgia Senate. He is a member of ALEC's Health and Human Services Task Force.

There is no doubt that America needs health care reform, but from the bottom up—not from the top down. America needs health care reform that does not raise taxes, incentivizes healthy lifestyles, offers portability, and helps lower insurance premiums. We need reform that is prevention-focused and patient-centered. And, we need health care reform that does not increase our national debt.

Yes, there is an alternative to ObamaCare. Let's join together and continue to explore viable conservative health care solutions that will improve the lives of Americans without compromising both our health and the financial future of our great country. ■

Freedom of Choice in Health

This map encompasses the 2009-10 legislative session.



Opposition to the centerpiece of President Barack Obama's health reform agenda—the requirement that citizens purchase health insurance or else be fined or jailed—originated in Arizona in 2006 and was brought to nationwide attention with ALEC's model *Freedom of Choice in Health Care Act*. The legislation is designed to give states standing in the current constitutional challenge of the federal individual mandate; empower states to file future, 10th Amendment-based lawsuits against the federal individual mandate; and empower the attorney general to litigate on behalf of individuals harmed by the mandate.

ALEC legislators in 42 states sparked a nationwide rebellion covered by nearly every major media outlet in the country—and ALEC's model served as the basis for *Commonwealth v. Sebelius*, Virginia's first-in-the-nation federal health reform challenge.

IN PRINT

Washington Post - "Health-care Overhaul is up Against Long Campaign Across U.S.," May 12, 2010.

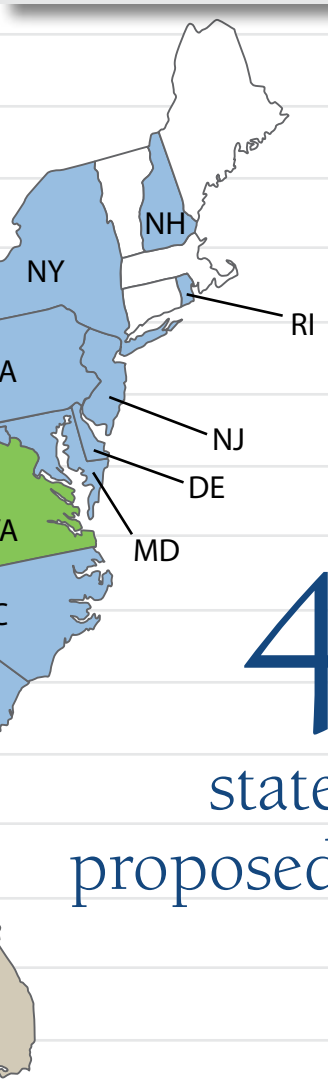
Investor's Business Daily - "States to Wage 2-Front Attack on Health Bill," March 22, 2010.

CNN.com - "Idaho Challenges National Health Care Proposal; More States may Follow," March 17, 2010.

Politico - "States Race to Pre-empt Health Reform, " Feb. 9, 2010.

Care Act

- Bills announced
- Bills enacted
- Bills introduced
- Measures on ballot



42
states with proposed legislation

Associated Press - "States Seeking to Ban Mandatory Health Insurance," Feb. 1, 2010.

Washington Times - "Federal Health Care Foes Plot for State Opt-outs," Jan. 19, 2010.

Governing - "Top 10 Legislative Issues to Watch in 2010," Dec. 31, 2009.

New York Times - "Health Care Overhaul and Mandatory Coverage Stir States' Rights Claims," Sept. 28, 2009.

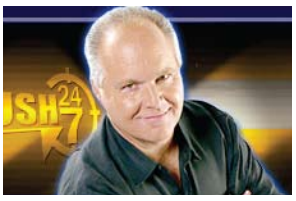
ON THE AIR

Sen. Judson Hill (GA)
appeared March 19, 2010 on Fox Business Channel to highlight his *Freedom in Health Care Act*.

ALEC's Christie Herrera
appeared March 18, 2010 on Fox News Channel's "Special Report with Bret Baier" to discuss state-based challenges to federal health reform.

Glenn Beck & Sarah Palin
talk about Idaho's health freedom efforts on the March 18, 2010 edition of Fox News Channel's "The Glenn Beck Program."

Sen. Jane Cunningham (MO)
appeared Feb. 9, 2010 on KMOV (St. Louis's CBS affiliate) to discuss Missouri's efforts to secure health care freedom.



Rush Limbaugh
mentioned ALEC's nationwide initiative on the Feb. 1, 2010 edition of "The Rush Limbaugh Show."

Rep. Nancy Barto (AZ)
appeared July 1, 2009 on MSNBC's "The Ed Schultz Show" to discuss Arizona's first-in-the-nation health freedom efforts.

States Shouldn't be Bullied by ObamaCare

BY GRACE-MARIE TURNER

ObamaCare represents the greatest power grab by Washington from the people and states since the New Deal. And now, in an effort remarkably similar to how ObamaCare was passed, the law's supporters are attempting to sugarcoat the benefits of the new law while ignoring its huge tax and spending increases and the inevitable increase in health costs.

The states would be well-served to stand up to Washington and let federal officials know that they won't be bullied into running the programs mandated by the new health overhaul law that the majority of Americans don't support and don't believe we can afford.

Many of the states are already pushing back against ObamaCare. For example, 19 states have decided to let the federal government manage the new state high-risk pools created by ObamaCare rather than serving as contractors to run this poorly-constructed, under-funded program.

ObamaCare mandates the creation of new high-risk pools in each state to provide insurance for people with pre-existing conditions and expensive health conditions. It provides $5 billion to run the pools until 2014, when people would be transferred into the new health insurance exchanges.

But a report by the National Institute for Health Care Reform finds that this money would likely cover only about 200,000 people, out of as many as seven million who may qualify. The Obama administration's own Medicare actuary found that the $5 billion will likely run out next year or in 2012.

At that point, states—already grappling with harsh budget realities—could be forced to pay for the federal program, which would run into the billions of dollars. In short, ObamaCare's high-risk pool plan is an unfunded liability—and 19 states were wise in deciding that they aren't going to help bail out Washington.

ObamaCare will hurt state budgets in other ways as well. Washington will gobble up billions of dollars in Medicaid pharmacy rebate money by taking it from the states. In addition, the dramatic expansion of Medicaid up to 133 percent of poverty, new and more generous benefit requirements for Medicaid coverage, and the large administrative costs of ObamaCare are just three other examples of costs states will incur.

In fact, the state of Indiana—with only about two percent of the nation's population—estimates that ObamaCare will cost Hoosiers between $2.9 and $3.6 billion additionally over the next 10 years—money the state doesn't have and doesn't want to spend on a program they don't support.

States should push back against these burdensome federal regulations.

ObamaCare's biggest Washington take-over will involve establishing new health insurance exchanges in 2014. These exchanges are supposed to be run by the states, but the federal government will set the rules and regulations about who can participate and what benefits must be offered.

Some in Washington want a government single-payer system and to eliminate private health insurance altogether. You can bet that many of them will be the federal officials charged with helping to regulate the health insurance exchanges in the states. That's part of the reason states should push back against these burdensome federal regulations and not roll over as the exchanges are established.

Grace-Marie Turner is president of the Galen Institute, a non-profit research organization focusing on market-based health reform ideas, and an advisor to ALEC's HHS Task Force.

States also might want to examine all of their options concerning health insurance for state employees. ObamaCare's restrictive mandates will cause health care costs for state workers to rise at an untold cost to states. As Indiana Gov. Mitch Daniels has pointed out, paying a penalty and dumping state employees onto the public exchanges might be cheaper for states just as it will be for many businesses. That may be a short term cost savings to states, but a long-term cost explosion for federal taxpayers.

States that play the ObamaCare game are likely to lose control over decisions involving health care options for their citizens and spending mandated by the new law. States should stand up to Washington and remind the federal government that the Constitution preserves authority to the states and the people, not to an all-powerful federal government. ■

The Evolution of Government Health Care

A Portrait of Disdain

BY REP. CHARLICE BYRD (GA)

In campaign speeches, public addresses, press conferences and rallies, President Obama and the incoming administration tickled the audiences' ears with promises of a new day, restitution for wrongs and the transformation of an America seemingly out of control. "Hope and change!" "Yes we can!" Audible confetti showered the audience, short on definition and long on emotion.

The one emotion quickly expressed by the new administration was disdain as it painted the American people with the brush of ignorance composed on a background of contempt:

June 15, 2009 - Reuters

"If we do not fix our healthcare system, America may go the way of GM; paying more, getting less, and going broke," President Obama said, "It is a ticking time bomb for the federal budget. And it is unsustainable for the United States of America."

By this time, the American people were to have forgotten about the $1.487 trillion in additional spending (the $700 billion Troubled Asset Relief Program in January and the $787 billion stimulus bill in February). By June, clearly, health care was positioned as the death knell to the federal budget.

July 21, 2009

The Heritage Foundation reports that in a conference call, leftist bloggers asked the president, "Is this true? Will people be able to keep their insurance and will insurers be able to write new policies even though [federal health reform] is passed?" President Obama replied: "You know, I have to say that I am not familiar with the provision you are talking about" Later in the call, Obama promises yet again: "If you have health insurance, and you like it, and you have a doctor that you like, then you can keep it. Period."

Obama admits that he is not aware of the details of his landmark legislation and staple of his campaign trail speeches and literature. However, he continues to tout the talking points.

Charlice Byrd represents the 20th District in the Georgia House of Representatives. She is a member of ALEC's Health and Human Services Task Force.

"But we have to pass the bill so that you can find out what is in it, away from the fog of the controversy."

- U.S. House Speaker Nancy Pelosi

Aug. 25, 2009 - *Politico*

"Reform supporters are planning to hold more than 500 events between Wednesday and when lawmakers return to Washington Sept. 8, ranging from neighborhood organized phone banks to professionally staffed rallies with hundreds of people … But the talk of broad health insurance reform does not mean that progressives have backed off their push for a government-run insurance option."

In the firestorm of town halls, legislators rediscover their constituents and learn that the government takeover of healthcare is not wanted or needed. The Left mobilizes professional and amateur forces to counter the debate.

Sept. 12, 2009 - Bloomberg

President Obama told 13,000 people gathered to rally around his healthcare proposals at Minneapolis's Target Center. "If you misrepresent what's in the plan, we will call you out."

Three months into the national debate of his landmark legislation, President Obama threatens those who "misrepresent" the plan, although he does not know what is in it.

Nov. 18, 2009 - *Politico*

In the Battle of the Health Bills, the Senate wins out, bulk-wise—weighing in at 2,074 pages. The House health reform bill was a mere 1,990 pages when introduced. That means the Senate bill—like the one in the House—runs more pages than *War and Peace*, and has nearly five times as many words as the Torah.

To put this in further perspective, the Constitution is four pages, the Declaration of Independence is one page, the Bill of Rights is one page, the legislation for the interstate system is 24 pages, the Civil Rights Act is eight pages, and legislation giving women the right to vote is one page.

Dec. 16, 2009 - ABC News

"This actually provides us the best chance of starting to bend the cost curve on the government expenditures in Medicare and Medicaid ... Because if we don't do this, nobody argues with the fact that health care costs are going to consume the entire federal budget," Obama said.

This is the same day that Congress voted to raise the national debt limit by over $290 billion.

March 9, 2010 - www.Speaker.gov

"But we have to pass the bill so that you can find out what is in it, away from the fog of the controversy," writes Speaker of the House Nancy Pelosi.

Fifty-three percent of Americans oppose healthcare according to a Rasmussen poll, 48 percent oppose ObamaCare according to Gallup, and 43 percent are opposed according to the Associated Press. Americans know what is in the bill and the only fog of controversy seems to be deception by the administration.

March 17, 2010 - Interview of President Obama by Fox News Channel's Bret Baier

OBAMA: "This notion that this has been not transparent, that people don't know what's in the bill; everybody knows what's in the bill. I sat for seven hours with—"

BAIER: "Mr. President, you couldn't tell me what the special deals are that are in or not today."

OBAMA: "I just told you what was in and what was not in."

BAIER: "Is Connecticut in?"

OBAMA: "Connecticut—what are you specifically referring to?"

Nine months later and five days before the vote on the legislation, President Obama is still unaware of the details of his flagship legislation.

The pleas of the American people fell on deaf ears on March 22, as the takeover of the health insurance industry was complete by a vote of 219-212—and the President's signature sealed its fate.

As budgets bled red ink, governors scrambled to protect their states. In Georgia, the General Assembly passed the *Healthy Georgians Act of 2010* (Senate Bill 411). The three page (not 2,000+ page) Act incorporates language that prohibits any federal or state law from compelling any individual or person from participating in any healthcare system.

In an ironic twist, ObamaCare may have stripped Congress of health coverage for itself. The legislation removed members of Congress and Congressional staff from their health insurance plan and forces them to join the ObamaCare exchanges that will not exist until 2014.

As writer Elbert Hubbard once stated, "Men are not punished for their sins, but by them."

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Health Care Policy and Constitutional Rights

The Health Care Freedom Amendment

BY DAVE ROLAND

Ed. Note: *This report is excerpted from excellent testimony by constitutional attorney Dave Roland on Alaska House Joint Resolution 35, which was heard before the Alaska House Finance Committee on April 10, 2010. Although HJR 35 failed to pass the Alaska House and died with session's end, the bill's sponsors say they'll reintroduce the legislation in the 2011 session.*

Co-Chairperson Hawker, Co-Chairperson Stoltze, Vice-Chairperson Thomas, and members of the committee, I thank you for the opportunity to offer this testimony. My name is Dave Roland, and I am a policy analyst for the Show-Me Institute, a non-profit, non-partisan, Missouri-based think tank that supports free-market solutions to the state's social challenges. Prior to joining the Show-Me Institute, I spent several years in Washington, D.C., gaining expertise in constitutional law as a litigator with the Institute for Justice, a public-interest law firm that specializes in the protection of Americans' liberties. The ideas I will offer today are my own, and should not be taken as necessarily representative of the organizations with which I am affiliated.

Among the elements of the new health care reform law that was passed by Congress is a requirement that almost every adult would either have to purchase a health insurance policy or face punitive fines to be collected by the Internal Revenue Service.[1] There has been widespread debate in legal circles about whether the courts would uphold such a requirement, but lawmakers in at least 40 states are trying to do what they can to insulate their citizens from such a requirement. In Alaska, members of this legislature are considering

Dave Roland is policy analyst with the Show-Me Institute, a free-market, Missouri-based think tank. He has advised ALEC members in Kansas and Missouri on issues relating to the constitution and health care freedom.

1 The law makes exceptions for members of religious groups whose beliefs forbid the acceptance of modern medical treatments.

HJR 35, which very closely resembles the legislation known in other states as "Health Care Freedom" amendments. HJR 35, if passed by this legislature, would offer citizens the opportunity to modify the Alaska Constitution to formally recognize their right to decide for themselves whether they will participate in any private health care system. Under this amendment, the government would not be permitted to prevent citizens from offering or accepting direct payment for health care services, and neither could it substantially limit the purchase or sale of health insurance in private health care systems.[2]

My testimony today is not intended as an endorsement of any legislation, but rather to explain the policies implicated by the state bill and the federal law just mentioned. I will particularly address the constitutional issues raised by one element of the federal health care reform law, the way that courts would likely resolve those constitutional issues, and the likely impact of the Health Care Freedom Amendment on the courts' resolution.

Should Everyone Have Health Insurance?

The linchpin of the new federal health care reform law is a requirement that by 2014 almost every adult in the nation must obtain a health insurance policy that would meet certain requirements imposed by Congress. In addition to the fact that many Americans currently carry health insurance policies that would *not* fit the requirements Congress is considering, there are also many who have reasons for choosing to remain uninsured. A brief look at the basic mechanics of the health insurance industry will help illustrate why some people make these choices.

Insurance is gambling, both for the insurers and the insured. The insurer looks at your profile and makes a careful statistical determination of how much your health care is likely to cost them over a given period of time. They then charge you a premium that—if their calculations are correct—would allow them not only to cover your expenses, but also to pay their employees and to make a profit on top of that. Their risk lies in the possibility that you might incur costs greater than they expect and/or sooner rather than later. But the odds are heavily stacked in their favor. These companies are very good at making their guesses, and the large pool of resources that results from their customer base means that, just like a casino, they almost always come out ahead.

While many Americans currently carry health insurance policies that would not fit the requirement Congress is considering, there are also many who have reasons for choosing to remain uninsured.

For the insured, there is also a gamble involved. If, in fact, the insurance companies are correct (as they usually are), the insured will end up paying far more for their health care than they would have if they had remained uninsured. This is the risk they assume in order to gain peace of mind that, should a catastrophic injury or illness occur sooner rather than later, they will be taken care of. But, financially speaking, the great majority of people would be better off putting 85 percent of what their insurance premium would have been into a savings account earmarked for health care expenses.[3] Then, whenever health care costs emerge, the money is ready to be used—and, importantly, it can be used for any procedure and any health care provider the insured prefers.[4]

So the health insurance trade off is, the insured sacrifices extra money and a significant range of choice as to providers and procedures for the assurance that they will have their expenses covered if they should need treatment sooner than they would otherwise be able to pay for it. It is not a necessity, and a large majority of people would ultimately be better off if they simply saved their money instead of giving it to insurance companies. That is why it very easily could make economic sense to forgo health insurance.

While some people may not carry health insurance because it is unaffordable, many Americans choose not to purchase health insurance. Some people's religions may not permit the use of modern medicine, while others may not believe it to be effective. Still others are simply confident enough in their propensity for health that they are willing to risk the costs of illness or injury in order to direct their money to concerns that they believe to be more pressing for themselves and their fam-

2 It appears from the current text of the Health Care Freedom Amendment that the legislature would retain the ability to pass a comprehensive, tax-based, single-payer public health insurance system, so long as in doing so it did not either outlaw the sale or purchase of private insurance policies or restrict citizens' abilities to offer or accept direct payment for health care services.

3 Even the best of health insurance companies usually only apply about 85 percent of the premiums they receive on their clients' health care costs.

4 Most health insurance companies place limits on the doctors from whom a policy holder can receive treatment as well as on the types of treatment that are covered.

ilies. And there are some who, recognizing that most people pay far more to insurance companies than they are ever likely to need for their own treatment costs, would prefer to self-insure by creating their own health fund. For each of these people, a congressional directive to purchase a health insurance policy would mean giving up a huge amount of money—as well as a significant amount of autonomy and privacy—committing themselves to a contract for goods and services that they do not want, and in some cases may be prohibited from using.

The Federal Constitution

As we all remember from high school, congressional authority is limited to those powers explicitly granted by the Constitution.[5] In this case, the question would be whether the Constitution gives Congress the authority to punish citizens for refusing to purchase health insurance.

Those arguing in favor of the law's constitutionality suggest that this authority is part of part of Congress' power "to regulate commerce … among the several states[.]"[6] It is true that since 1937 courts have generally interpreted this power very broadly,[7] resulting in a U.S. Supreme Court decision that a farmer named Filburn was bound by agricultural regulations regardless of whether he took his grain to market.[8] More recently, the Supreme Court also held that Angel Raich was subject to federal drug laws even though her medical marijuana was homegrown and neither bought nor sold.[9]

But courts have also recognized that congressional authority under the Commerce Clause is limited. In *U.S. v. Lopez*, the Supreme Court held that the Commerce Clause did not permit Congress to create a federal law banning possession of firearms in a school zone.[10] In *U.S. v. Morrison*, the court struck down a law that addressed the subject of gender-based violent crime.[11] The primary reason that the court struck down the laws in *Lopez* and *Morrison* was that the subjects Congress sought to regulate lacked a clear nexus with commerce among the states.

Even though much of the health insurance industry is handled within the bounds of individual states,[12] courts will likely find that health insurance as a whole is an issue with a sufficient connection to interstate commerce to permit congressional regulation. But now that Congress has passed a law mandating that individuals must either buy health insurance or face financial sanctions, courts will still have to answer a very specific question: Does the power to regulate interstate commerce give Congress the authority to penalize citizens *who do not wish to engage in commerce*?

As Prof. Randy Barnett pointed out at a Heritage Foundation debate,[13] the Supreme Court has never faced such a question, so we cannot be certain of its answer. I tend to agree with Barnett that the Court's response will likely hinge on the solicitor general's ability to explain which aspects of citizens' lives (if any) would remain beyond the reach of congressional regulation if the Court permitted these mandates to be enforced. If the Solicitor General offers a reasonable response that acknowledges clear limits to the powers available under the Commerce Clause, the Court may sustain the individual health insurance mandate. If not, I believe that the majority of justices will strike the mandate as unconstitutional.

Some professors have argued that even without relying on the Commerce Clause, authority for the health insurance mandate could be found in Congress' power "to lay and collect taxes …

5 These eighteen powers are enumerated in Article I, section 8, of the U.S. Constitution: 1) To tax and spend for "the common defense and general welfare of the United States"; 2) To borrow money; 3) To regulate commerce with foreign nations and among the several states; 4) To establish rules governing naturalization of citizens and bankruptcies; 5) To coin money and regulate its value; 6) To punish counterfeiting; 7) To establish a postal service and post roads; 8) To establish copyright laws; 9) To constitute a federal court system inferior to the Supreme Court; 10) To punish piracies on the high seas and offenses against the law of nations; 11) To declare war and make rules concerning captures on land and water; 12) to raise and support armies; 13) To provide a navy; 14) To make rules to govern the army and navy; 15) To provide for the use of militia to enforce laws, suppress insurrections, and repel invasions; 16) To provide for organizing, arming, and disciplining the militia; 17) To govern the District of Columbia; and 18) to make laws "necessary and proper for carrying into execution the foregoing powers."

6 U.S. Const. Art. I, § 8.

7 Prior to 1937, the power of the federal government was regularly held in check by the Supreme Court. A number of factors, including President Franklin Roosevelt's threat to pack the court with his own appointments in order to ram through New Deal legislation, led to what has been termed a "constitutional revolution". For the past 73 years, the general rule has been for courts to presume that the Commerce Clause grants Congress nearly unlimited authority to regulate the behavior of citizens—particularly as pertains to their ability to obtain, keep, and use property.

8 *Wickard v. Filburn*, 317 U.S. 111 (1942).

9 *Gonzalez v. Raich*, 545 U.S. 1 (2005).

10 *U.S. v. Lopez*, 514 U.S. 549 (1995) (finding no clear connection between mere possession of a firearm in some proximity to a school and the stream of interstate commerce).

11 *U.S. v. Morrison*, 529 U.S. 598 (2000).

12 In part as a result of federal law, it is very unusual for individuals to be able to purchase insurance from companies outside the state in which they are currently domiciled.

13 Video available at http://volokh.com/2009/12/09/video-of-heritage-session-on-constitutionality-of-health-care-mandate/.

[to] provide for the … general welfare of the United States,"[14] or even in the 16th Amendment's authorization of an income tax.[15] I disagree. While the taxation power *might* permit Congress to create a tax-based, universal public health insurance system like Medicare,[16] this sort of comprehensive, tax-based program is not the object of the penalties that would be assessed upon those who choose not to comply with the insurance mandate. In fact, these penalties cannot properly be considered "taxes" at all unless their primary purpose is to raise revenue for the government rather than to regulate the behavior of citizens.[17] Thus, while Congress can properly impose fines for violation of a law that it is permitted to enforce pursuant to its authority to regulate commerce, it may not call a fine a "tax" in order to justify penalties for behavior *not* within its authority to regulate commerce. Furthermore, even if the fees for failing to purchase health insurance were classified as a tax authorized by Article I, section 8, Congress is specifically denied the authority to impose capitation taxes "unless in proportion to the census," a requirement that the current proposal does not seem to meet.[18] Therefore, Congress may not justify the mandate and its penalties unless they are enacted pursuant to one of the other powers enumerated in Article I, section 8.

The next question courts would have to answer is whether the issue should be reserved to the states under the 10th Amendment.[19] This is shakier ground for a constitutional defense than one would really like to have. While the original intent of the 10th Amendment was clearly to keep the federal government in its proper, limited sphere, the test of the amendment states that it applies only where courts have determined that a specific power has not been delegated to Congress. If a court has already located congressional authority in either the Commerce Clause or the taxing power, it is a near certainty that it will also determine that the 10th is simply inapplicable as a barrier against the federal statute.

After considering the question of whether Congress generally has the authority to create an individual health insurance mandate, the question will then become whether such a mandate violates liberties preserved under the first nine amendments to the U.S. Constitution. The relevant provisions are contained in the First, Fifth, and Ninth Amendments.[20] The Supreme Court has previously recognized that the Constitution protects citizens' rights to associate with others of their choosing,[21] to enter into contracts, to make their own decisions regarding health care, and, of course, their right to privacy.[22] A violation of any one of these rights could be sufficient to invalidate the health insurance mandate.

Unfortunately, merely establishing an infringement of constitutional rights does not usually end the analysis. In fact, the Supreme Court has long permitted infringement of these kinds of liberty, as long as the government could advance an interest in doing so that a majority of the justices considered

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14 U.S. Const. Art. I, § 8.

15 U.S. Const. Amendment XVI.

16 This might be possible, though politically impractical. First, they could not apply such a tax against everyone. It would have to take the form of some kind of an income tax or else it would violate the constitutional prohibition on "capitation" or "direct" taxes. See Article I, section 9. So, in order to mirror the effect of the current proposal while relying on the taxing power, they'd have to jack up the income tax rates by two percent across the board, then offer a two percent tax credit for anyone who obtains a qualifying health insurance policy. That would likely pass muster, constitutionally, but it would almost guarantee an enormous political backlash because people hate having their taxes raised—even if many would have a relatively easy way to get out from under it. This approach, by the way, would also make it much harder to exempt people with religious reasons for not obtaining health insurance, which would be another major knock against such a plan.

17 "The test to be applied is to view the objects and purposes of the statute as a whole and if from such examination it is concluded that revenue is the primary purpose and regulation merely incidental, the imposition is a tax and is controlled by the taxing provisions of the Constitution. Conversely, if regulation is the primary purpose of the statute, the mere fact that incidentally revenue is also obtained does not make the imposition a tax, but a sanction imposed for the purpose of making effective the congressional enactment. There is a marked distinction between taxation for revenue, as authorized and limited by Article 1, Sections 2 and 9 and Clauses 3 and 4 of the Constitution, and the imposition of sanctions by the Congress under the commerce clause. The power of Congress to 'regulate commerce' is the power to prescribe the rules by which commerce is to be governed and the Congress is at liberty to adopt any method which it deems effective to accomplish the permitted end. Congress has a discretion as to what sanctions shall be imposed for the enforcement of the law and this discretion is unlimited so long as the method of enforcement does not impinge upon some other constitutional prohibition." *Rogers v. United States*, 138 F.2d 992 (6th Cir. 1943)

18 It might be argued that the penalties for failing to obtain health insurance could be considered an "income tax" of the sort that is exempted from the limitations of Article I, section 9. I think that such a penalty could not be considered an "income tax" because it would be selectively applied and collected separately from the general income tax authorized in the Sixteenth Amendment.

19 U.S. Const. Amendment X.

20 While the U.S. Supreme Court has rarely discussed the Ninth Amendment as a substantive source of individual liberties, its text—"The enumeration in the Constitution of certain rights shall not be construed to deny or disparage others retained by the people"—suggests that it should be seen as such. See Justice Arthur Goldberg's concurring opinion in *Griswold v. Connecticut*, 381 U.S. 479 (1965).

21 U.S. Const. Amendment I.

22 U.S. Const. Amendments V and XIV (Due Process Clause).

The courts would have to decide whether a state's guarantee of liberty to its citizens can protect them from actions of the federal government that would violate that liberty.

sufficiently important. In the case of the individual health insurance mandate, the government's interest is to make insurance premiums more affordable and, thus, to increase the number of people with access to health care. The courts will have to balance this interest against the liberty and privacy interests violated when citizens are forced to purchase coverage that they do not want and may have no intention of using. My opinion is that, particularly given the extremely high value that several current justices place on protecting the privacy rights of individuals, it will be difficult for the Solicitor General to convince a majority that the potential for lower health insurance premiums (because, in fact, there is no guarantee that the plan will work in the way Congress intends) can justify forcing someone to disclose private information about themselves and their health care.

The Health Care Freedom Amendment

If everything I've discussed above fails to persuade the courts to strike down the individual health insurance mandate, then the arguments will come down to state constitutional protections. This is one reason (but not only *one* reason) why Alaskans should take the Health Care Freedom Amendment seriously.

The Bill of Rights in the U.S. Constitution does not demarcate the outer limits of individual freedoms to which citizens are entitled. Rather, it merely establishes a baseline of liberty that cannot be violated by any level of government. The states, however, each have their own constitutions, and those documents can—and frequently do—provide an even higher level of protection for liberty than is afforded by the U.S. Constitution. Generally speaking, these additional protections are only applied against the actions of state and local governments, but if Congress tried to enforce a law that directly violated the terms of the Health Care Freedom Amendment (or some other freedom guaranteed under a state constitution), the courts would have to decide whether a state's guarantee of liberty to its citizens can protect them from actions of the federal government that would violate that liberty.

This is currently an open question. There are cases in which federal courts have noted that the application of a federal statute could result in a violation of certain freedoms secured under state constitutions. In several of these cases, the courts required the government to come up with a sort of alternative structure that would respect the state constitutions – but in each of those cases there were also usually indications from Congress that they wanted to avoid violating state constitutional freedoms. In the case of the individual health insurance mandate, it would seem clear that Congress is not concerned with respecting state constitutional protections. This would set up a battle under the U.S. Constitution's Supremacy Clause.

The Supremacy Clause, found in Article VI, reads as follows:

> *"This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any state to the Contrary notwithstanding."*

Of course, the central question here will be just how the courts will apply this language. The answer may not be as simple as it seems. Despite the text's indication that state laws and constitutions are subject to federal laws and treaties, a look into history shows that several important Founders rejected the idea that Congress could always enforce laws deemed unconstitutional by the states. When in 1798 Congress passed the Alien and Sedition Laws, which made it a criminal offense to publicly criticize certain government officials, James Madison—widely known as the Father of the Constitution—and Thomas Jefferson—author of the Declaration of Independence and the sitting Vice-President—drafted the Kentucky and Virginia Resolutions, in which those states rejected the constitutionality of the acts.[23] The U.S. Supreme Court was not called upon to resolve the question of whether states could legitimately deny

23 Madison later said that, in his opinion, these resolutions were primarily useful as tools through which the power of Congress could be called into question—though not necessarily nullified. He believed that similar resolutions would signal to other states the potential necessity of modifying the current system of government to eliminate further abuses.

congressional authority in this way, but up until the Civil War different states repeatedly adopted similar measures.[24]

Without any directly applicable judicial precedent, some legal scholars have attempted to guess at how the justices might be inclined to resolve such a conflict between state constitutional liberties and federal laws. One of my colleagues, Clint Bolick, a co-founder of the Institute for Justice and the current leader of a constitutional litigation center at the Goldwater Institute in Arizona, has noted a recent judicial trend in which the Supreme Court has shied away from allowing federal laws to trump state constitutional requirements.[25] This might well signal that the justices are inclined to protect freedoms enshrined in state constitutions, but the only way we will be sure is if the U.S. Supreme Court is presented with a direct conflict. The Health Care Freedom Amendment, if adopted by the people of this state, could provide just such a conflict.

Summing Up

Now that Congress has passed the health care reform law, it will likely be several years before a case evaluating the constitutionality of the individual health insurance mandate reaches the U.S. Supreme Court. In fact, we have already seen a number of lawsuits filed in federal courts. Once the federal district courts have decided that this issue is ripe for adjudication, they are likely to deal with the issues quickly, render a decision, and kick the cases up to the circuit courts. Once the circuit courts have weighed in on the constitutional issues, the Supreme Court will choose the set of facts on which it will base its consideration of the law. Keep in mind that it doesn't have to take the *first* case to get resolved by a circuit court, although it only takes four justices agreeing in order to get a case in front of the Supreme Court.

When the issue gets in front of the Court, I believe that proponents of the mandate (in other words, the Solicitor General) will have to satisfactorily answer at least two vitally important questions if they are to win a majority: 1) If the Commerce Clause permits Congress to force individuals to purchase goods and services that they do not want, where is the limit of that power—if, indeed, a limit can be articulated?, and 2) Is Congress's interest in (potentially) lowering the cost of health insurance premiums sufficiently compelling as to justify forcing individual citizens against their will to associate with others and to divulge to them all sorts of private information about one's health?

I believe, based on the current composition of the Supreme Court,[26] that the individual health insurance mandate would probably be found unconstitutional, either as a violation of the Commerce Clause or the individual right to privacy. I cannot see any of the four conservative-leaning justices (Roberts, Alito, Scalia, or Thomas) approving such a mandate as an exercise of the Commerce Clause, nor can I see any of the three liberal-leaning justices (Ginsburg, Breyer, and Sotomayor) disapproving the mandate. The deciding factor, then, will be whether Justice Kennedy will go for or against it, and I believe that will largely depend on how the Solicitor General articulates what limits might remain on congressional authority if the mandate is approved.

A more interesting question is how the justices might vote on the question of whether the right to privacy precludes the imposition of an individual health insurance mandate. Justices Thomas and Scalia have both rejected the notion that there *is* any such right to be found in the constitution, making it unlikely that they would rely on this right to strike down legislation as unconstitutional. On the other hand, several of the more liberal justices have previously written passionately about the importance of the right to privacy. It is possible that the privacy question might result in a majority of justices voting to strike down the mandate, but with Scalia and Thomas dissenting on this point.

Either way, the Supreme Court is likely to find that an individual health insurance mandate violates the provisions of the U.S. Constitution. While the Supreme Court is thus unlikely to reach the question of whether the Health Care Freedom Amendment would be seen as an additional bulwark for liberty, the adoption of this amendment would at a minimum offer the potential for a case that would test the boundaries of state sovereignty under our current constitutional system. ■

24 Many northern states refused to enforce the provisions of the Fugitive Slave Acts passed by Congress. Indeed, South Carolina's attempted nullification of a tariff passed by Congress in 1832 nearly sparked secession and armed conflict.

25 Instead, the Supreme Court has generally tried to avoid finding a direct conflict between federal laws and state constitutional provisions. For example, in *Wheeler v. Barrera*, 417 U.S. 402 (1974), Congress had passed Title I, which required public educational funds to be distributed to disadvantaged children regardless of the schools they attended. This conflicted with Missouri's constitutional prohibitions against public dollars being sent to religious schools. Rather than address this apparent conflict, the Supreme Court noted that the legislative history of Title I suggested that Congress was sensitive to the presence of such state constitutional provisions and that they did not intend to require violation of those provisions. To get around the problem, the Court decided that a separate public fund—which would not be part of the state treasury—would be established as the conduit for Title I funds to the assistance of needy children in religious schools.

26 The April 9, 2010, announcement that Justice John Paul Stevens would be retiring from the Supreme Court is unlikely to alter this analysis. Justice Stevens was a reliable vote in favor of governmental authority to regulate individual citizens' lives, and he was widely expected to favor the constitutionality of the new health care reform law. Thus, no justice appointed by President Obama will improve the likelihood of the mandate's constitutionality being upheld—and they might actually become a vote *against* the mandate's constitutionality.

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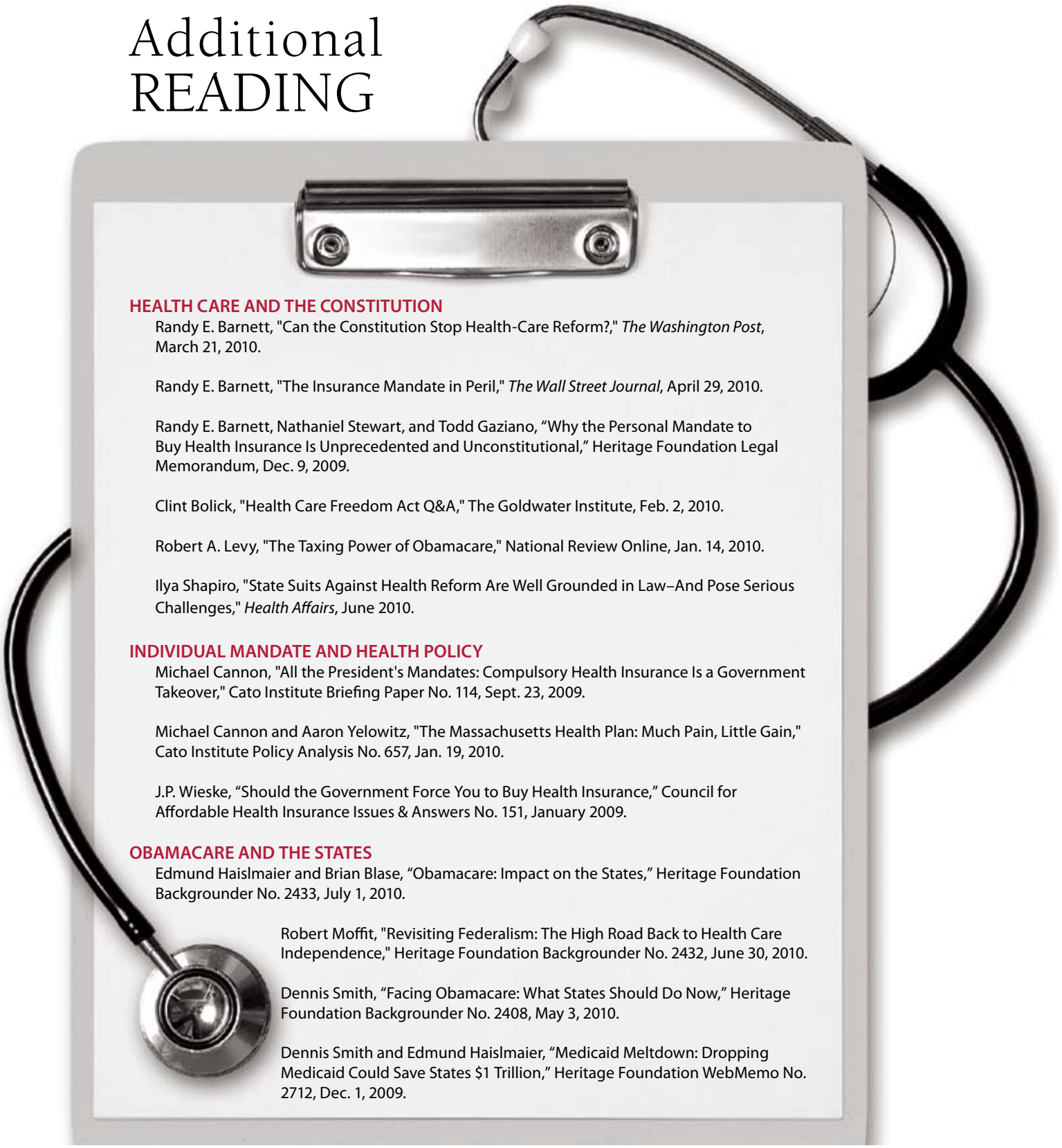

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What Washington, D.C. Could Learn from Washington State on Health Care Reform

BY REP. DOUG ERICKSEN (WA) AND ROGER STARK

In a far away corner of the land, a long time ago, a health care battle took place. The place was Washington state, the year was 1993, and the debate centered on a controversial measure modeled on HillaryCare called the *Washington Health Services Act*.

Now, from ground zero of HillaryCare, a new movement of consumer-based health care solutions in Washington state has emerged led by a coalition of state lawmakers, the non-partisan Washington Policy Center, and ALEC.

President Bill Clinton recognized early in his first term that his national health care plan needed a state incubator. First Lady Hillary Clinton went on to say "features of the Washington plan will be features of any plan that comes out of Congress." Washington Governor Mike Lowry reciprocated by emphasizing he was "pleased that President Clinton's reform proposals so closely resemble Washington state's new law."

With pressure from the White House, the legislative process was top-down as bill revisions came across fax machines from Washington, D.C. By the time the final vote was taken, few state lawmakers had actually read the entire bill. The *Washington Health Services Act* passed on a near party-line vote by a liberal legislature and was signed by the governor in May 1993.

As their policy compass—HillaryCare—lie in ruins in the other Washington, those responsible for the state legislation were left to nervously watch the implementation of new taxes, bureaucracy, premium caps, insurance regulations, mandatory health insurance coverage, and government-sponsored purchasing cooperatives.

While provisions of the *Washington Health Services Act* would be phased in over a six-year period, negative effects appeared in the first year. By 1995, many of the state's private health insurers had pulled out of the market. From 1994 to 1997, the state's six largest private health insurers lost more than $116 million in the individual market. Those insurers that stayed had to raise premiums—by 40 percent in some instances. Rising costs prompted many consumers to drop their coverage, thus increasing the state's uninsured rate. By 1999, the individual market had fallen apart—with individuals and families in 30 of Washington's 39 counties not having any private health insurance options.

Washington state also became a magnet for patients from around the country who had serious and expensive medical conditions because they knew they could get immediate health insurance coverage. Many people took advantage of the new system in other ways. For example, some women would enroll in a health insurance plan after becoming pregnant and drop their coverage following the births of their babies. People would also change from a low-cost health insurance plan with a high deductible to a high-coverage health insurance plan with a low deductible, receive major medical procedures or treatments, and then change back or drop their coverage.

The *Washington Health Services Act* led to rising health care costs and fewer options for consumers. These outcomes were generated by the legislation's centralized financing and delivery of health care, including the rationing of health care, limiting consumer choices for doctors, and consumers paying for coverage they did not need or necessarily want.

The health care issue was on the minds of Washington state voters in the 1994 general election. The state House of Representatives went from 65 Democrats and 33 Republicans to 61 Republicans and 37 Democrats. The Democratic majority in the state senate was downsized to just one seat. Post-election analysis revealed that as voters learned more about the radical health care changes made by their citizens' legislature, the greater their opposition grew.

While many provisions of the *Washington Health Services Act* were repealed in 1995, remaining issues caused private health insurers to leave the state. The state went from having 19 private health insurers in 1993, to only having three remaining today. The aftermath continues to hurt families, individuals and small businesses.

The story of Washington state should serve as a cautionary tale for those making decisions on health care reform in Washington, D.C., but the message has not yet been received. To understand where our country is going, all we have to know is where Washington state has been the last 17 years.

Doug Ericksen represents the 42nd District in the Washington House of Representatives and is the ranking Republican on the House Health Care and Wellness Committee. Roger Stark is a retired surgeon and a health care policy analyst with Washington Policy Center, a non-partisan public policy research think tank in Washington state.

On March 9, Speaker of the House Nancy Pelosi said, "...we have to pass the bill so that you can find out what is in it" when describing the new federal health care bill to the National Association of Counties. The paradigm has now shifted from whether the legislation will pass, to what it will mean for families, individuals, small businesses, and states. The more we learn, the more reason there is for concern.

The federal health care bill is expensive and complex. It is hard to know its exact costs and understand the new, expansive authority it provides to the Internal Revenue Service and Health and Human Services Department. With the analysis we have undertaken, our greatest concerns with the legislation are that it will:

- Increase taxes by $500 billion, which will hit the middle class especially hard;
- Take us toward a government-controlled health care system, instead of a patient-controlled system;
- Cause health insurance premiums to rise due to mandates on private plans;
- Cut Medicare by $500 billion, which could limit seniors' access to health care;
- Dramatically increase the number of people on Medicaid, when the program is already struggling financially;
- Result in more costs, time and mandates for small businesses; and
- Cost nearly $1 trillion at a time when federal spending and the national debt are out of control.

We support the efforts of those, including Washington State Attorney General Rob McKenna, who believe the federal health care bill unconstitutionally imposes new requirements on states and its citizens. The unprecedented federal mandate that requires all Washingtonians to purchase a certain type of health insurance appears to violate the Commerce Clause and 10th Amendment of the U.S. Constitution. However, this question will likely be answered by the U.S. Supreme Court.

So, what can be done moving forward? First and foremost, the federal health care bill must be repealed. Unlike Washington state, the country should not wait two years to pursue repeal. By then, too much damage could be done.

Second, a top-down approach should not be used for health care reform. While Washington state's actions in 1993 were a prime example of how not to implement health care reform, this is not to say that states should refrain from taking the lead. On the contrary—states can, and should, play a leading role. However, it must be done right.

For example, new consumer-based health care solutions have come forward in Washington state. This movement is based on the principle of fixing what is broken, while protecting what is working well. It is focused on breaking down government-created barriers, protecting individual freedoms and limiting government growth.

This new movement of health care reform has specific goals and outcomes, which include lowering health care costs; providing more choices for health insurance; increasing access to health care; and strengthening the safety net for our most vulnerable citizens.

These principles, goals and outcomes are backed by solutions based upon the work of the ALEC Health and Human Services Task Force. The following solutions were part of a 10-point plan the Washington Policy Center recommended and House Republicans in Washington state put forward in the 2010 legislative session:

House Bill 1871 Allows Washingtonians to choose from a wide variety of health care plans available in other states.

House Bill 1868 Provides more benefit plan options that meet the needs and budgets of small employers.

House Bill 1866 Allows health care plans specifically designed to meet the needs and budgets of young adults.

House Bill 2875 Provides Health Savings Accounts (HSAs) for state employees.

House Bill 1383 Passed in 2006, this measure would require the Public Employees Benefit Board to move forward on an HSA option and report to the legislature if an HSA option will still not be available by January 2011. The governor has refused to implement this legislation.

House Bill 1867 Repeals certificate of need laws to allow more options and choices.

House Bill 1865 Allows the option of purchasing a health care plan that does not include the "every category" provider mandate.

House Bill 1872 Repeals the two percent insurance premium tax on HSAs, and provides all employers and self-employed individuals a tax credit for providing health insurance.

House Bill 2807 Transforms the state's Basic Health Plan into a premium-subsidy program for legal residents ages 35 to 64.

House Bill 2814 Brings comprehensive medical malpractice reform to keep doctors in the state and prevent lawsuit abuse.

House Bill 2669 Protects the rights of Washingtonians to make their own health care choices by prohibiting laws and rules that interfere with an individual's right to make his or her health care choices.

If these measures were allowed to move forward, Washington and other states would directly address many of their health care problems and be less reliant on whatever does or does not happen in Congress and Washington, D.C. ■

Pitfalls with Federal Health Reform

What State Legislators Need to Know

BY REP. LINDA UPMEYER (IA) AND BRAD TROW

"We have to pass the bill so that you can find out what's in it." That's what House Speaker Nancy Pelosi told the National Association of Counties on March 9. And since then, Americans of every walk of life have taken some time to try and find out what was in that bill. In the few months since President Obama signed the 2,400-page law into effect, a day rarely goes by when a new provision isn't discovered. And as each day passes, more legislators across the country ask the same question: What have they gotten us into?

While many of the most controversial provisions of the new law do not go into effect until 2014, there are numerous changes to America's health care system that will be implemented over the next few months. These changes are likely to create even more anger and confusion in a public that is already upset with Washington's decision to move forward.

As usual, it will be left to state legislators to deal with the consequences of Congress's haste. Here are a few of the issues that legislators will be wrestling with in the upcoming months:

High Risk Pools: A Risk to Your State's Budget?

One of the first provisions being implemented is the creation of high risk pools in every state to provide health coverage to those with a pre-existing condition. After the release of a Government Accountability Office (GAO) report last year that found nearly four million Americans fall into this category, Congress decided they needed to set up a coverage plan to serve as a health insurance bridge for these folks until 2014. The reform bill provides $5 billion for states to provide coverage through the pools for the next three and a half years.

States were given a choice—run the program yourself or let the feds run it for you. Not only did Congress provide the funds for the risk pools, they also provided the eligibility rules and limits on how much participants can be expected to contribute for their coverage.

It is important to note that high risk pools are not a new concept for states. In fact, 35 states have already established their own pools. In Iowa, our high risk pool plan covers nearly 3,000 members. The cost of the coverage is paid for by monthly premiums and assessments on health insurance carriers serving the state. The annual cost of the program today is about $25 million.

Unfortunately for Iowa, while the GAO report found that there were 34,000 Iowans who could benefit for a high risk pool, the Congressional appropriation is just 40 percent of what it costs to run our current pool. This means that Iowa's new pool will likely serve just 1,000 citizens. Recent analysis of this part of the bill has concluded that just 200,000 Americans could be served under this appropriation. This is likely to be the first of many instances where the health care bill has over-promised and then under-performed.

What happens when these new pools run out of money? Federal officials have been clear that they intend to administer the risk pools "conservatively." Every legislator knows what that means. When the federal money runs out, it's up to state officials to make the tough decision—cap the program or find another source of revenue to keep it going.

Linda Upmeyer represents the 12th District in the Iowa House of Representatives. She is a member of ALEC's Board of Directors, and serves as chairman of ALEC's Health and Human Services Task Force.

Brad Trow is a research analyst with the Iowa House of Representatives.

Who Pays for the Young and Invincibles?

Another area where state legislators are going to be caught in the crossfire between Washington and the public is coverage for the "young and invincibles." These are the young Americans who believe they'll never need health insurance and don't get it. The Obama administration has spent considerable time and energy trumpeting a provision that allows parents to keep adult children covered under their health insurance policy through age 26.

Conceptually, this is not a bad idea. Since most young adults are healthy and rarely need medical attention, their premiums are considerable lower than their parents'. But when they need care, it usually means there is a serious condition or accident. Allowing parents to choose to extend their coverage means there will be some source of payment for

the care. Here in Iowa, we had already adopted a similar provision in 2008 for unmarried young adults under age 26. In making this reform, we made sure there were two key provisions included.

First, extending the coverage is the parents' choice. As parents, we understand there can be those times when we take steps to make sure our kids are protected, and other times when you need to give them a gentle nudge out of the nest. We made sure mom and dad made the decision as to provide insurance or not. Also, we made sure that extending the coverage did not get passed onto other policy holders. As a parent, if you decided to provide insurance to your child, it is up to you and your child to pay for it. It does not get built into everyone's premium.

These key issues apparently did not register with Congress when they put this provision together. Section 2714 of the bill appears to put the decision in the hands of the child, not the parent. And even more troubling, the section is totally silent on how the coverage is to be paid for. This means that everyone covered by an ERISA-regulated plan is going to pay for this change.

While Washington focuses on pushing insurers and employers to implement this provision before its enactment date of September 23, human resources offices across the nation are calculating how much the new provision will raise their insurance premiums. We've talked to a number of businesses who are putting off implementation as long as they can, because they can't afford the hike in premiums.

The federal plan also creates headaches for states like Iowa, which moved ahead on young adults. The bill gives states the choice to maintain their existing laws for a few years or conform to the federal regime. It is just a matter of time before the health care advocates come to Iowa and demand that we put the kids in charge instead of the parents.

The Biggest Problem: Medicaid

Maybe the biggest issue state legislators will have to deal with in the near future is Medicaid. With state budgets continuing to be hammered by the anemic recovery fostered by the Obama administration, finding ways to pay for Medicaid are more and more difficult. Congress has promised to cover just about every Medicaid increase in the future. But they exacted a price from states now.

Just like the federal stimulus bill passed in 2009, Congress has again tied the hands of states in dealing with their Medicaid programs. States are not allowed to make changes to eligibility standards or to many of the services provided under the program. This means states are left with two equally bad choices. They can lower provider reimbursements or raise taxes.

In Iowa, the decisions made over the past four years created a situation where nearly half of this year's Medicaid budget comes from one-time funding sources. To maintain the program at its current level, Iowa would have to find new funding or adjustments in excess of $560 million in our next budget year. That amounts to half of Iowa's annual cost for Medicaid. That task will be made even more difficult thanks to Congress's restrictions.

Only the Beginning

These three areas are just the first hurdles that states will have to clear over the next few months. As the Obama administration continues to move forward with implementation, state legislators will be faced with a myriad of issues and choices. Among these will be:

- Does your state decide to establish a health insurance exchange, or do you let Washington do it for you?

- What do you do with all the new information that health insurance plans are required to provide to your state's insurance commissioner, and how will you handle the calls for action to crack down on insurers?

- Does your state employee health plan meet the still-unwritten guidelines for being a "grandfathered" plan, or does your state have to comply with the new health coverage mandates immediately?

- Even if your state employee plan is grandfathered in, what changes can you make to the plan during these lean budget times?

- Where do you find the money to pay for the increased cost of state employee coverage when the new coverage requirements go into effect?

- How will the new medical loss ratios impact your state's health insurance market and will there still be competition for your constituents' coverage needs?

- What do you do about those Medicaid reimbursement rates when the federal government's enhancements expire?

- Does your state insurance commissioner have the staff and resources to perform the functions now required of them by the federal government?

- Will your state participate in the CLASS long term care insurance plan, and who will pay the premiums—state employees or the taxpayers?

The debate over health care didn't end on March 23. It's only just begun. While that will create a lot more work for legislators and state bureaucrats, it does allow Americans to still raise the most important issue for them—reducing the cost of health care. And wasn't that Congress's original goal? ■

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GAINING MOMENTUM

Long-Term Care Taking Root in States

BY SEN. RENEE UNTERMAN (GA)

A majority of Americans age 50 and over want to remain in their own homes as long as they can, according to the American Association of Retired Persons Public Policy Institute.

Nine in 10 Americans say it is important to improve coverage for services that help people remain in their home instead of going into a nursing home, according to Lake Research Partners.

In Georgia, we're looking for patient-centered, affordable solutions to serve the long-term care population. And, some states are getting that message and taking it to heart, with New Mexico leading the way. It leads the country in supporting individuals with long-term service needs in the community. In the AARP study, "A Balancing Act," New Mexico was identified as the state with the highest percentage—61 percent—of Medicaid long-term services dollars spent on home- and community-based services (HCBS).

"New Mexico has one of the most balanced LTC (long-term care) systems for older people and adults with physical disabilities in the nation, and recent Medicaid trends indicate that the state is continuing to make even more progress towards rebalancing," the study said.

A lot of that direction toward more HCBS, and away from an institutional bias, comes from the 2008 implementation of the Coordination of Long Term Services (CoLTS) program. This statewide program serves more than 36,000 elderly and disabled Medicaid recipients and is a joint initiative of the New Mexico Human Services Department and the New Mexico Aging and Long-Term Services Department.

Here are a few philosophies and lessons learned from some states where the programs are working successfully with ALEC private-sector member Amerigroup, a health insurer that focuses on the unique needs of the financially vulnerable, seniors and people with disabilities on public funded programs.

New Mexico

In 2008, the State implemented the CoLTS program, a managed long term care initiative that is authorized via a 1915(b)(c) waiver and that builds upon the infrastructure established by New Mexico's statewide managed care program, known as Salud!, for beneficiaries of Medicaid and the Children's Health Insurance Program. The CoLTS program is a joint initiative of the New Mexico Human Services Department (HSD) and the New Mexico Aging and Long-Term Services Department. This initiative was procured via a competitive Request for Proposals, and was designed over several years. In addition, CoLTS built upon features of the state's Money Follows the Person (MFP). Stakeholder involvement was critically important in developing the concepts of CoLTS. Advocates, providers, Native American tribal representatives, other government partners and experienced consultants all helped design the program.

According to HSD Secretary Pamela Hyde, CoLTS was designed to address the fragmented mix of institutional, state plan and HCBS services in New Mexico and to improve limited coordination and integration. CoLTS covers primary, acute and long-term services in one integrated program that incorporates Medicare and Medicaid services and funding in an approach that is seamless to beneficiaries, according to Secretary Cindy Padilla. CoLTS offers a choice of culturally responsive, appropriate and quality long-term services; provides a system of services that minimizes stays in institutional settings, by increasing access to less restrictive HCBS; promotes improved health status and quality of life and reduced dependency on institutional care; and uses best practices from other states to improve coordination and reduce fragmentation. CoLTS enrollees consist of several groups, including those who formerly were enrolled in New Mexico's Disabled and Elderly (D&E) waiver program; adults receiving personal care services from the Medicaid Personal Care Option (PCO) program; residents of nursing facilities; individuals who are eligible for both Medicare and Medicaid, but who have not yet accessed the system of long-term services in the state; and certain qualified individuals with brain injuries.

Renee Unterman represents the 45th District in the Georgia Senate. She is a member of ALEC's Health and Human Services Task Force.

The cornerstone of CoLTS is coordination of care and services, which encourages maximum involvement of the participant in the service planning process, more services being available in home- and community-based settings, and decreased dependency on institutional levels of care. Through the program, New Mexico is working to rebalance its Medicaid long-term supports

and services system from heavy reliance on nursing facility services to extended use of HCBS, according to the state's CoLTS web site.

Since the program began, participating beneficiaries have been receptive to the concept of having their own Service Coordinators. In addition, nursing facilities in the state have indicated they like the concept of on-site Service Coordinators who can help residents. The Service Coordinator approach not only promotes independent living and improved health outcomes, it also helps to reduce costs to the state Medicaid program because of fewer institutionalizations.

While the program still is too young to draw definitive conclusions, all signals point to a successful start when quality, service and savings projections are considered.

Texas

Texas Health and Human Service Commission's (HHSC) program overview calls STAR+PLUS a Medicaid coordinated care program designed to provide health care, acute and long-term services and support through a coordinated care system. This program provides a continuum of care with a range of options and flexibility to meet individual needs. The program increases the number and types of providers available to Medicaid clients.

Participants enroll in a coordinated care organization (CCO) and receive Medicaid services through those health plans. Through these health plans, STAR+PLUS combines traditional health care (such as doctor visits) and long-term services and support, such as providing help with daily activities in a participant's home, home modifications, respite care and personal assistance. Service coordination is the main feature of STAR+PLUS. Medicaid clients, their families and providers work together to help clients coordinate health, long-term and other community support services, according to HHSC.

Enrollment in the program is required for Medicaid recipients who live in a STAR+PLUS Service Area and for people who have a physical or mental disability; qualify for Community-Based Alternative 1915(c) waiver services; receive Medicaid because they are in a Social Security Exclusion program or are 21 or older and receive SSI benefits, according to HHSC.

Long-term services and support provided by the health plans include day activity and health services, personal attendant services and home delivered meals. Additional services include adaptive aids, adult foster care home services, adult day care services, assisted living, emergency response services, medical supplies, small home modifications, nursing services, respite care and therapies (occupational, physical and speech-language).

Savings have grown annually since the implementation of the STAR+PLUS program, according to a study by the Texas A&M Public Policy Institute. In the report, "STAR+PLUS Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality and Cost-Effectiveness," savings totaled $6.05 million in the first waiver period compared to $123 million in the second waiver. "Waiver period two savings represents an almost 17 percent reduction in state Medicaid costs as compared to FFS (fee-for-service) costs for this population," the study said.

Amerigroup currently serves 55,000 Texas members participating in the STAR+PLUS program. Since we began the program, the company's participating members have demonstrated the following improvements:

- Members accessing community-based adult day care services has increased by 38 percent;
- Members accessing personal assistance services has increased by 32 percent; and
- Inpatient stays have decreased by 28 percent.

Florida

The objective of Florida's LTC Diversion Program is to maximize HCBS to meet the needs of the frail elderly through the delivery of coordinated medical and LTC services. Amerigroup works with the state to ensure that more than 30,000 elderly patients receive the services they need to stay safely in the least restrictive environment.

In order to participate in the LTC Diversion Program, beneficiaries must be 65 years or older; Medicaid eligible up to the Institutional Care Program level; Medicare parts A and B beneficiaries; reside in the service area; and be at risk of nursing home placement.

According to information from the Florida Department of Elder Affairs, the average cost of keeping a beneficiary in a nursing facility for one year is close to $50,000. By contrast, the annual cost to the state for a member participating in the LTC Diversion Program is $21,000. Under Medicaid, the average cost to serve an eligible patient in a nursing home is $3,839 per month while the average cost under the Diversion Program is $1,624 per month. The subsequent difference is $2,215 in saved nursing home expenses per person per month. During the fiscal year 2007-08, the state avoided $294 million in costs that would have otherwise been dedicated to nursing home fees.

Both legislators and the private sector alike share the goal of expanding health care choices, particularly for those in nursing facilities or those at risk for nursing home placement. Through these LTC programs in New Mexico, Texas, Florida, and Tennessee, we'll all work to improve access to community-based care, ensure appropriate services delivery through our care coordination process, improve health outcomes, and implement cost containment initiatives. ■

New Model Legislation

The full text of all ALEC model bills is available online to ALEC members. Please feel free to contact ALEC's membership department at (202) 466-3800 if you need help accessing this legislation.

COMMERCE, INSURANCE, AND ECONOMIC DEVELOPMENT TASK FORCE

Michael Hough, Task Force Director

Online Motor Vehicle Insurance Verification Act

An Act relating to motor vehicle insurance; providing for the establishment of an online verification system; providing for codification; and providing an effective date.

Business Exit Interview Act

An Act to require the Department of Development to compile a report of companies that relocated out of this state and to attempt to determine the motivation behind the relocations.

Resolution in Opposition to a Consumer Financial Protection Agency

A Resolution opposed to the legislation being considered by Congress that would create a Consumer Financial Protection Agency (CFPA).

EDUCATION TASK FORCE

Dave Myslinski, Task Force Director

Founding Documents Act

The Founding Documents Act would require during the high school years the teaching of a semester-long course on the philosophical understandings and the founders' principles, which are the foundation of our form of government for a free people, as incorporated in the Declaration of Independence, the United States Constitution, and the Federalist Papers.

The Higher Education Accountability Act

To expand access to public information and be accountable to the taxpayers of the state of [State], each public institution of higher education must annually report to the legislature and in a prominent consumer-friendly location on its website, in a common format, the following information on institutional profile, affordability, student and faculty engagement, student achievement and institutional efficiency.

Inclusive College Savings Plan Act

This Act will increase opportunities for state residents to invest in 529 college savings plans.

HEALTH AND HUMAN SERVICES TASK FORCE

Christie Herrera, Task Force Director

Resolution on Cord and Placenta Blood Banking and Research

This Resolution recognizes the need for increased public awareness about the use and research of umbilical cord blood and placenta blood banking to provide treatment options for debilitating or terminal diseases, and encourages ongoing research and private enterprise.

ENERGY, ENVIRONMENT, AND AGRICULTURE TASK FORCE

Clint Woods, Task Force Director

State Resolution to Withdraw from Regional Climate Initiative

This Resolution urges the governor of [State] to terminate state participation in regional initiatives to conduct cap and trade for greenhouse gases or implement low carbon fuel standards.

Resolution to Retain State Authority Over Coal Ash and Non-Hazardous Waste

The EPA has consistently designated coal ash, often used in asphalt and other important byproducts, as non-hazardous waste until recently when efforts were made to reclassify it and take states' regulatory authority over it.

Environmental Priorities Act

Convenes a one time council to perform a comprehensive assessment of environmental priorities with cost benefit analysis in an effort to prioritize for state legislators the most bang for your buck in environmental programming as well as to expose budget busters.

PUBLIC SAFETY AND ELECTIONS TASK FORCE

Michael Hough, Task Force Director

Resolution in Support of the National Prison Rape Elimination Commission Standards

A Resolution supporting the National Prison Rape Elimination Commission released national standards for the prevention, detection, response, and monitoring of sexual abuse in U.S. detention facilities.

Recidivism Reduction Act

This Act requires that a to-be-determined percent of offenders be supervised in accordance with evidence-based practices within four years, as well as that a to-be-determined percent of state funds for offender programming be spent on programs that are evidence-based within four years. This Act also requires community corrections agencies to improve policies and practices for crime victims, to provide employees training on evidence-based practices, and to set aside a portion of funds for research on program effectiveness.

Swift and Certain Sanctions Act

This Act requires community corrections agencies to adopt a set of graduated sanctions and rewards to respond to violations and compliance with the conditions of supervision. This Act also establishes authority for agencies to impose graduated sanctions and rewards through an administrative process.

Community Corrections Performance Incentive Act

The provisions of this Act are intended to reduce crimes committed by probationers and the number of probationers revoked to prison by giving probation departments a share of the savings to the state in reduced incarceration costs when they reduce both new offenses by probationers and revocations to prison.

TAX AND FISCAL POLICY TASK FORCE

Jonathan Williams, Task Force Director

ALEC's Principles of Taxation

The fundamental principles presented here provide guidance for a neutral and effective tax system; one that raises needed revenue for core functions of government, while minimizing the burden on citizens. Guiding Principles of Taxation are: simplicity transparency, economic neutrality, equity, complementary, competitiveness and reliability.

Vote on Taxes Joint Resolution

This Resolution supports a Vote on Taxes Amendment to the Article V of the United States Constitution to call a limited constitutional convention. The Vote On Taxes Amendment would require that Congress obtains the consent of the governed before imposing new taxes, increasing the federal debt, mandating unfunded spending requirements upon the states and increasing federal spending above the base year adjusted annually for inflation and population change. The Amendment would allow two-thirds of the state legislatures to propose an identically worded Amendment which would be ratified if approved by a majority of voters in three-quarters of the states.

Automatic Income Tax Rate Adjustment Act

The Automatic Income Tax Rate Adjustment Act provides for a biennial reduction in the state adjusted gross income tax rate on residents, nonresidents, and corporation if year-over-year revenue from the adjusted gross income tax exceeds certain amounts. The Budget Agency shall make the determination before July 1 of each even-numbered year and for the rate reduction to take effect in taxable years beginning in the immediately following odd-numbered year.

TELECOMMUNICATIONS AND INFORMATION TECHNOLOGY TASK FORCE

Seth Cooper, Task Force Director

Resolution Opposing the Expansion of the Federal Trade Commission's Rulemaking Authority

This Resolution opposes the expansion of the FTC's regulatory powers.

Resolution on Government Tax Preparation and Electronic Filing

This is a revised and updated Resolution supporting the state free file program, through which middle and low income earners can file their state income taxes online for free. ■

ALEC Task Forces

ALEC public and private sector members, serving on ALEC's nine national Task Forces, draft, introduce, debate, and vote on Model Legislation throughout the year. To date, ALEC members have approved over 700 model bills, resolutions, and policy statements, all available online at www.alec.org. Every year, hundreds of ALEC Model Legislation is introduced in the states. In the 2009 Legislative season, 115 ALEC bills were enacted.


"I want to give work to people, not take it away. I need something that's affordable. Electricity from coal does that for me."
Olivia Albright owns AOA Products, a small company in Toledo, Ohio. Olivia's business may not be big by some people's standards. The business has grown from something that she started in her garage, and today employs seven people ... who Olivia refers to as family. But the story doesn't end there because Olivia has big dreams. She wants to grow her company, be able to employ more people, and even be in the position to offer health-care coverage to her employees.
Low-cost electricity from coal is a part of Olivia's story, and she knows that. Every machine at AOA runs on electricity. And Olivia knows that to keep those machines running and her business profitable ... she depends upon affordable electricity. She's lucky, in a sense, because in Ohio, where she works, coal, America's most abundant and affordable resource, provides 85% of their electricity. Using coal to generate electricity not only keeps energy costs low for businesses like Olivia's, but it also helps create jobs for American workers.
Learn more about Olivia's story at www.americaspower.org.
Olivia Albright
Owner
AOA Products – Toledo, Ohio
CLEAN COAL.
AMERICASPOWER.ORG

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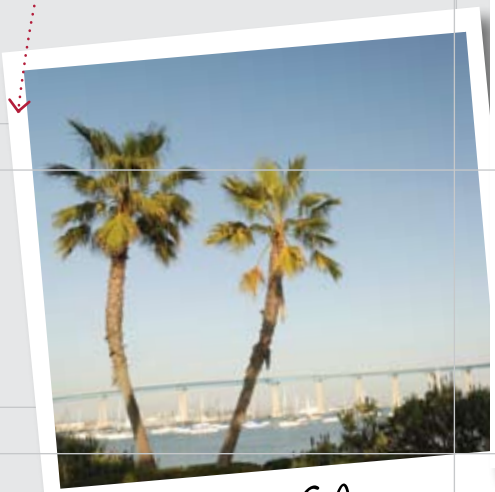
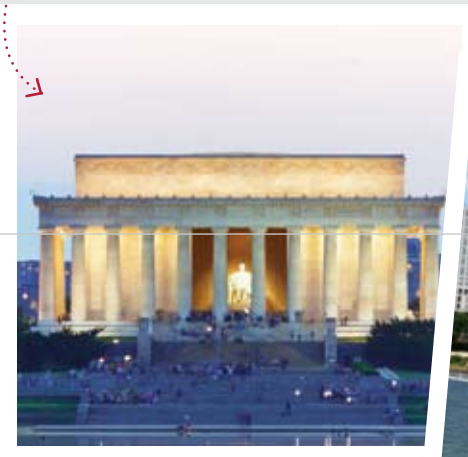
Add these upcoming ALEC events to your calendar!

Calendar

Annual Meeting
Aug. 5-8, 2010


San Diego, CA

States & Nation Policy Summit
Dec. 1-3, 2010


Washington, D.C.

Spring Task Force Summit
April 29-30, 2011


Cincinnati, OH

For more information about ALEC's annual conferences, visit www.alec.org